

**Revised Strategy  
for  
NATIONAL FAMILY WELFARE  
PROGRAMME**

**A SUMMARY**



**DEPARTMENT OF FAMILY WELFARE  
MINISTRY OF HEALTH AND FAMILY WELFARE  
GOVERNMENT OF INDIA  
NEW DELHI**

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www.sochara.org

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## PREFACE

0.1 The Prime Minister has desired that the family welfare and population stabilisation programme be re-designed and a time-bound action plan be drawn up to bring about a swift decline in the birth rate. This intention was also emphasised in the President's Address to the Joint Session of Parliament on 20th February, 1986.

0.2 The Ministry of Health and Family Welfare had commissioned three marketing research organisations in the private sector to carry out independent evaluation of the family welfare programme and make diagnostic studies about contraceptive attitudes and practices of the people. In addition, more than 120 studies and research papers on various aspects of the Family Welfare Programme have been analysed. The findings of these studies have formed a substantial basis for the new strategy.

0.3 The strategy gives family planning the broadest possible dimensions of social engineering including not only Health and Family Welfare but also child survival, women's status and employment, literacy and education and socio-economic development including anti-poverty programmes. It seeks to streamline the entire spectrum of programme management, formulate for family welfare a multi-disciplinary and integrated effort of all relevant developmental agencies and elevate the programme into a genuine voluntary people's movement. This will be the realisation of the call given by the late Prime Minister Shrimati Indira Gandhi, who said "Family Planning must become a movement of the people, by the people, for the people".

## CHAPTER I

### CURRENT SCENE

1.1 Census of 1981 counted India's population at 685 million, double the 1947 figure of 342 million. India presently has 15% of the world's total population and 2.4% of the total land area. At the beginning of the century, population growth was not steady; balance of deaths over births was tenuous; diseases such as plague, cholera, malaria and famine reduced population in the country. In fact, the second decade of the century hardly witnessed any population growth with birth at 48 and deaths at 47 per thousand population. However, since 1921, there has been a rising trend in population growth

primarily due to decline in mortality rates.

1.2 The country is passing through a demographic phase which is marked by a fairly high fertility and moderate mortality. Currently, the birth rate is around 33 and death rate is around 12 per thousand population with infant mortality rate of 104 per thousand live births. Per capita income is low and the incidence of poverty is high: more than a third of the population lives below the poverty line. Female literacy is only 28.5%. Present population of the country is estimated at around 750 million and it is increasing by about 15 million every year. This rapid increase in population has serious implications for the overall socio-economic development of the country. Success on the population front is vital for the success of all national development and anti-poverty efforts and is highest on the agenda of the Prime Minister on the overall strategy to steer the nation into the new millennium.

1.3 India has a multi-lingual society with wide variations in demographic situation and socio-economic conditions. People practise different religions and there are numerous cultural identities. Varying social customs and beliefs favour large family size and militate against adoption of modern methods of contraception.

1.4 The mean age of marriage of women is 18.7 years which is very low. A vast majority of poor people still perceive children as assets in financial and other terms. There is near universal desire to have at least one or two male children. The prevailing demographic situation, socio-economic conditions and large scale diversities make the programme of population control a most challenging task.

1.5 The National Family Planning Programme started in 1951 with a clinical approach. Extension education approach was adopted in mid-sixties and since late seventies Family Planning service delivery system has gradually expanded into a community oriented service network in which family planning services are offered as part and parcel of the overall health package of services particularly the maternal and child health and nutrition activities. Although, reduction in birth rates over the years has fallen short of the Plan targets, the Programme has made a significant impact on fertility. During 1970s, the birth rate declined from 40 to 34, but during 1979-84, it has been stagnating around 33.

1.6 The programme is estimated to have averted about 70 million births in the country so far at

a total investment of Rs.2400 crores upto the end of 1984-85. Thus, only about Rs.340 have been spent per birth averted and this includes the cost of a substantive infrastructure which has been set up. The average annual population growth rate which rose from 1.25% in '40s to 1.96% in the '50s and 2.20% in the '60s reached a plateau during '70s when the growth rate was 2.25%. Since the inception of the programme, in every Plan period, there have been varying levels of shortfalls in the Family Planning performance. In particular, the programme suffered a serious setback during 1977-82 and picked up during the later period of the VI Plan. During the VI Plan period, achievements in sterilisation, IUD, CC and OP users have been 79%, 82%, 85% and 129% respectively. Nearly full target realisation of all family planning methods, an all-time annual record of over 19 million acceptors and an overall couple protection rate of over 35% has been achieved in 1985-86, the first year of the VII Plan.

1.7 A recent study (covering over 32,000 respondents) conducted through private marketing research companies has provided valuable information in addition to confirming and re-inforcing several findings of studies conducted earlier. The findings of the Study have highlighted the areas and issues that need to be focussed upon and have provided valuable clues to framing communication approaches and messages. The salient research findings are:

- Awareness of Family Planning is very widespread and over 60% people have attitudes favourable to restricting/spacing births.

- A majority of couples want 3 or more children with a preferable composition of 2 sons and one daughter.

- Customs and traditions play a major role in determining the age at marriage and there are favourable trends towards increase in age at marriage.

- Literacy increases the acceptance of one son as ideal and is positively correlated with the increase in marriage age.

- Medical institutions in urban areas are accessible and are being increasingly utilised; in rural areas easy access is lacking and so is the utilisation of the institutions.

- Apathy and concern regarding the effects on health, religious beliefs and illiteracy are some of the major inhibitors to adoption of various methods of contraception.

FUTURE GOALS AND NEW APPROACHES

2.1 The long-term goal is to reach zero population growth rate by 2050 A.D. with an estimated population of around 1300 million. The medium-term goal is to reach Net Reproduction Rate of Unity (NRR : 1) by 2000 A.D. with a birth rate of 21, death rate of 9 and infant mortality rate below 60. According to the 7th Five Year Plan, the goals to be reached by 1990 are: birth rate of 29.1, death rate of 10.4 and Infant Mortality Rate of 87.

2.2 The specific objectives sought to be achieved during 1986-90 are to:

- Raise mean age at marriage for women over 20 years.
- Promote 'two-child family limit' as preferred family size.
- Substantially increase demand for contraception to achieve a couple protection rate of over 42%.
- Improve and strengthen the infrastructure and the quality of services.
- Enhance child survival through universal immunization and promotion of Oral Rehydration Therapy (ORT).
- Broad -base programme outreach by maximum involvement of non-governmental structures.
- Secure more effective Intra-sectoral and Inter-sectoral coordination.
- Streamline and improve programme management at all levels.
- Generate environment for fertility decline through relevant socio-economic interventions.

2.3 Major tasks to be achieved during the 7th Plan are:

- 31 million sterilisations, 21.2 million IUD insertions to be achieved and 14.5 million CC and OP users to be enrolled by 1989-90.
- Attempt to reach higher targets by converting awareness and knowledge into acceptance through mass media and inter-personal communication and motivation.

- Immunize 82 million infants and 90 million mothers.
- Universalize (150 million households) the use of Oral Rehydration Therapy.
- Population Education to all children in the age-group of 11-15 years (estimated 109 million).
- Family life lessons for youths (15-19 years).
- Population Education to those out of schools and colleges as a part of Adult Education and Non-Formal Education System.
- One round of training for all personnel (about eight lakhs) to improve professional and other relevant skills.
- Success of the Population Control Programme depends upon effective linkages of Family Welfare Programme with other socio-economic development programmes of poverty alleviation, literacy, child survival, women's status and employment, MCH, Family Planning, nutrition, etc. Intra- and Inter-sectoral coordination amongst various developmental departments will be strengthened and enhanced. The present health and family planning infrastructure will be properly consolidated, suitably augmented and optimally utilised through organisational and management improvement.
- Various apprehensions about the existing methods of family planning will be removed through effective communication programmes and improved quality of services.
- Research focus will be on developing more acceptable techniques and improving the acceptability of the existing methods.
- The two-child family norm will be promoted through a structured system of material and non-material incentives.
- Female literacy and employment programmes will be substantially stepped up.
- The Programme will be progressively debureaucratized and non-governmental structures promoted on a much wider scale to effectively involve the community at large in the programme.

### APPROACHES AND STRATEGIES

#### BEYOND FAMILY PLANNING

3.1 Certain socio-economic correlates greatly influence fertility behaviour. These factors would require to be effectively tackled for creating an atmosphere to promote a more rapid fertility decline. Special focus will be given on the following:

##### Increasing Mean Age at Marriage

3.2 In India, every year about 4½ million marriages take place of which in about 3 million the brides are in 15-19 age-group. The salient reasons for early marriage are: pressure from elders, customs and anxiety of parents about the grown up unmarried girls. There are indications that slightly higher age at marriage is now being favourably perceived. This encouraging trend will be re-inforced to raise the mean age at marriage for women beyond 20 years through specific interventions indicated below:

- Intensified publicity campaign highlighting the specific benefits of delayed marriage for the health of the mother and the children.
- Appropriate amendments in the law relating to the minimum age at marriage and its better enforcement.
- Generating a social reform movement through voluntary action to combat the forces of custom and tradition.
- Intensive motivation through grass-root level workers.
- Preferential treatment to those beneficiaries under the development programmes who conform to the minimum legal age at marriage.

##### Raising Status of Women

3.3 Significant impact on fertility can be brought about when the status of women is raised and they become equal partners in decision making. The perception of women about themselves and the way society perceives them will have to be changed by

a mass movement. A Programme for women's mobilisation and upliftment will constitute a major thrust of the programme to bring to surface the latent demand for family planning services. This will essentially have to be the nodal responsibility of the Ministry of Human Resource Development which will coordinate various schemes and activities in this regard. The major interventions would be:

- A mass movement through voluntary organisations engaged in women's welfare for creating awareness about the equal constitutional rights and opportunities for women thereby promoting an atmosphere enabling them to act as equal partners with men.

- A massive IEC campaign through multi-media channels and grass-root level workers and volunteers for creating awareness and generating activities to raise women's status in society.

- Particular focus on schemes of educational and vocational training to help young girls to build up skills for their gainful employment. Vocational and nutritional elements of the 'Gopalan Plan' for young village women should be considered by the Ministry of Human Resource Development.

- Comprehensive district-wise surveys about employment opportunities for women to explore larger avenues and linking of supportive services such as child care, community cooking, etc. with these schemes.

- Nationalised banks will be encouraged to provide loans through mahila mandals on collective security basis for income generating schemes to improve the economic status of women.

- Introduction of appropriate technologies like improved Chullah, bio-gas, inexpensive pressure cookers in rural areas to reduce burden of household work on women to enable them to participate in income generating activities.

### Female Literacy

3.4 It is well established that increase in female literacy leads to increase in marriage age, decline in birth rate and infant mortality rate. Female literacy in India is only 25% compared to male literacy of 47%. A massive push to the programme of female

literacy is necessary. The health workers and women volunteers will also be utilised for propagating the message of female literacy. Special focus will need to be given to resistant pockets. Proper linkages will be forged between female literacy programmes and the family planning programmes.

### Enhancing Child Survival and Development

3.5 A correlation between child/infant mortality and the desire to have large number of children is well accepted. A massive effort will be made in the 7th Plan to enhance infant and child survival and improve their physical and mental development. Programmes aimed at steep reduction in child and infant mortality will be given the highest priority. Special focus will be on the following activities:

- Programme of immunisation of expectant mothers and infants will be scaled up to reach the level of universal coverage by the year 1990. A Programme of this magnitude will be carried out with effective planning and management and will take care of production of adequate quantity of vaccines and streamlining of the service delivery system. Effective coordination with the Departments of Education and Women's Welfare and Child Development and voluntary organisations will be secured for the successful implementation of this mission.

- Nutrition intervention programme will include distribution of iron and folic acid tablets, administration of Vit. A to children, popularisation of iodised salt as prophylaxis against anaemia, blindness and goitre respectively.

- Promotion of Oral Rehydration Therapy and appropriate feeding practices to prevent a large number of infant and child deaths and growth interruptions resulting from childhood diarrhoea. A massive educational programme will be undertaken in this regard along with production and easy provisioning of Oral Rehydration Salt (ORS) packets.

- The Integrated Child Development Scheme has helped in improving MCH Services and reduction of birth rates in ICDS blocks. Accelerated expansion of the Scheme will greatly help in reducing birth rate.

### Linkage with Poverty Alleviation Programmes

3.6 There is a two-way relationship between fertility and poverty. During the 7th Plan anti-poverty efforts have been intensified. The major programmes in this regard are:

- The minimum needs programme which widens the access of the poor to the basic social services.
- Targeted assistance for social groups or areas like IRDP, NREP, RLEGP, TRYSEM.

It is proposed that while selecting beneficiaries under any of the poverty alleviation schemes, preference may be given to those who accept the small family norm. Couples with a two-child certificate and youths who voluntarily give a pledge to limit their family may be selected on preferential basis for grant of loan under various schemes. On the other hand, family welfare has to be promoted on a massive scale among the below poverty line segment of population so as to break the vicious circle of high fertility and poverty.

### Old Age Security

3.7 There is universal feeling that children especially sons are a security for old age. Old age security schemes are being run by States and few voluntary organisations, but these serve a very small fraction of the old age population. A tangible improvement in the social security coverage of old age people will have a definite impact on the desired small family norm. States will be persuaded to accord preference to parents of 'Small family' in providing old age pensions. Similarly, old age couples with small family and with no male child may be given overriding priority in admission to 'old peoples' homes.

## CHAPTER IV

### INFRASTRUCTURE

4.1 Various studies conducted through private and other organisations have highlighted that the existing infrastructure is not being optimally utilised mainly because of its inadequacies to provide proper services and relatively unfavourable attitudes of the people towards it. The major inadequacies relate

to poor quality of services, non-availability of staff, lack of empathy of the staff and poor management. Energising existing infrastructure with a view to optimising its output is an area requiring priority attention. Towards this end, some major steps are being taken which include clear delineation of job responsibilities, filling up of vacant posts, improving employees' motivation and service conditions, improving skills and capabilities of the staff, improving PHC management system by devising appropriate monitoring and supervision systems. In addition, Block and Village level Committees would be set up to involve people in exercising vigilance over the work of various functionaries. These measures will lead to a favourable perception of the health facilities by the target groups and optimal utilisation of the existing infrastructure.

#### Augmentation of Infrastructure

4.2 In the rural areas services are provided through a network of integrated Health and Family Welfare delivery system. There are 83,000 Sub-Centres, 11,000 Primary Health Centres and Subsidiary Health Centres and 650 Community Health Centres in the country. This infrastructure will be expanded as envisaged in the strategy approved at the time of formulation of Sixth Plan : One Sub-Centre for 5,000 population (3,000 population for hilly/tribal areas); a Primary Health Centre for 30,000 population (20,000 for HTA's) and one Community Health Centre for four PHCs.

4.3 In addition there are Community Workers which include about 5 lakh trained Dais, 3.8 lakh Village Health Guides. Village Health Guides Scheme will be overhauled and Dais Training will be intensified. Rural infrastructure would need to be augmented to bring services within easy reach of the beneficiaries.

Following table provides an idea of the present situation and the future needs :

Category Institution	Norm/Unit	Total No. required	In posi- tion as on 1.4.85	Target for 7th Plan (1985-90)
1. Dais	All practising Dais in rural areas.	5.80 lakhs (approx.)	5.14 lakhs (approx.)	1 lakh
2. Health Guides	One for every village/1000 population	4.50 lakhs	3.83 lakhs	1 lakh
3. Sub- Centres	One for 5000 population in general and one for 3000 popu- lation in tribal, hilly and difficult areas.	1.30 lakh	82,946	50,000 (54,883)
4. PHCs/ Subsi- diary Health Centres	One for 30,000 population i.e. one for every six sub-centres.	21,666	11,029 (7,284 PHCs & 3,745 Subsi- diary Health Centres)	12,390
5. Upgra- ded PHCs/ CHCs.	One for every 4 PHCs and for about 1 lakh population.	5,417	655	1,553

4.4 In the urban areas, there are 554 Post-Partum Centres at District level. 700 Post-Partum Centres have been sanctioned at the Sub-district level. During the Seventh Plan, 500 more Sub-district level Post-Partum Centres will be sanctioned. Studies have shown that the Post-Partum Programme has been providing Family Planning and M.C.H. services in a cost-effective manner.

4.5 There are 2583 Urban Family Welfare Centres

and 2592 beds have been approved under the scheme of Reservation of Sterilisation Beds. During the Seventh Plan, 2000 more sterilisation beds will be reserved in Non-Government sector. Even with this expansion, the urban infrastructure would not be adequate to cope with the work. The urban infrastructure will be revamped and reorganised to include extension services, particularly in the slum areas. In addition, voluntary organisations will be encouraged to set up and operate facilities in the urban areas and tax rebates will be proposed for the corporate sector coming forward to establish such facilities in Urban and Rural areas.

### Upgrading Technical Services

4.6 Poor quality of services has resulted in relative under-utilisation of facilities and lowering of the image and credibility of the health infrastructure. The apprehensions about possible adverse effects on health associated with sterilisation, IUDs and Pills are the major inhibitors to acceptance of those methods. Improving facilities and upgrading the technical quality of services will, therefore, be a major thrust for widening acceptance of Family Planning.

- All PHCs at Block level will be equipped to render the services like vasectomy, minilap, MTP and IUD insertions (Special emphasis will be given to improving the general environment in the PHCs).

- Medical Officers will be trained in a two-year time frame so that these basic family planning services are available on a continuing basis at Block Level PHC's. Various initiatives will be introduced to ensure enhanced services of doctors in rural areas.

- The medical curriculum will be amended to ensure that medical graduates undergo a minimum prescribed training in Family Planning Methods before they are awarded MBBS Degree - Post-Graduate courses will be established in Human Reproduction and Population Management in selected Institutes.

4.7 With a view to ensure observance of the existing guidelines, various types of FP services will be reviewed and updated to make them comprehensive and a strict system of providing appropriate follow-up services will be devised and enforced. One Centre of Excellence will be established in each major State

for planning and coordinating training programmes of medical personnel. These Centres will also be equipped to provide recanalisation facilities. Operation research projects will be commissioned through autonomous/private agencies to assess and evaluate quality of services and to suggest measures for further improvement.

4.8 Satisfied acceptor is the best ally of the programme. Only quality services can provide such satisfaction. Therefore, Monitoring and Evaluation of quality of services will be organised on systematic lines. High level technical committees at the Centre and State levels will be constituted to oversee and guide in all technical aspects of the programme. These Committees would give appropriate feedback to subordinate formations on a continuous basis. ICMR and the Centres of Excellence will be involved in concurrent evaluation of the technical aspects of the programme. Special teams will be deputed from the Central Government to review and enforce the quality of services.

#### Integration of Family Planning with other Socio-Economic Development Programmes

4.9 The 'clinical' approach of the '50s developed into 'extension' approach during '60s and during '70s, was further consolidated when Family Planning services were integrated with the Mother and Child Health services. This integration has been perceived to be beneficial both by workers and beneficiaries and has resulted in increasing FP acceptance. The new strategy will further deepen the integration of the Health and Family Planning systems at the primary health care level through reorientation programmes for health workers, strengthening of existing facilities and increasing delivery outreach by using special mobile teams. In this new integrated system non-governmental structures will be involved. Recognising the interplay of social factors like family structure, property rights, inheritance, old age security etc., the approach of integrated action would be extended to link Family Planning with other programmes of socio-economic development, e.g., Poverty Alleviation, Social Welfare, Agricultural & Cooperative Development, Women's Welfare, Education, Employment Generation and Urban Development.

INFORMATION EDUCATION COMMUNICATION

(DEMAND GENERATION)

5.1 The recent research study has shown that 60 per cent eligible couples hold favourable attitude to family planning. The percentage of those adopting family planning methods, however, is much less. The major communication task, therefore, is to convert the favourable attitude to practice of family planning. In working out the media campaign for the family welfare programme, professional talents available in Government and private sectors will be harnessed. A high level inter-media committee comprising communication professionals and eminent non-officials will be set up in the Ministry to advise on the use of appropriate media channels depending upon their capabilities for promoting specific messages and effectiveness of their reach.

5.2 Television is an effective medium but the availability of television sets in rural areas is limited. It is proposed to promote community TV viewing by providing sets with the co-operation of TV manufacturers and other development departments of the Government like Agriculture, Rural Development, Education, Women's Welfare, etc. Provisions of community TV sets could be linked to the interest shown by the village community in promoting acceptance of family planning. For villages which are outside the reach of TV transmission or have no electricity, it is proposed to undertake a programme for providing Video Cassette Players and generators with TV sets. Appropriate software will be developed with the help of professional experts which will provide a package of messages relating to Health, Family Welfare, Agriculture, Women's status and welfare and other key areas of socio-economic development.

5.3 Cinema, which is watched by a large number of people both in urban and rural areas and is a powerful communication medium, will be fully exploited through more systematic distribution of films and persuading the State Governments to grant entertainment tax exemption liberally to films with family planning as the dominant theme. Emphasis will be given on films aimed at dispelling doubts and fears about methods of contraception and such films will be shown

to rural masses in an interesting package organised with suitable entertainment. Newspapers, magazines and other print media will be utilised imaginatively. Journalists and Editors will be encouraged to write on population themes.

5.4 Multi-media communication campaigns will be mounted with primary focus on :

- Reinforcing the two-child family limit norm;
- Promotion of inter spouse communication;
- Child survival programme;
- Increasing the age of marriage;
- Neutralising male preference syndrome; and
- Improving the image of family planning and health workers.

Communication messages will be targeted not only at eligible couples but also other important influencers. The communication strategy will aim at maximising the total impact through judicious mix of mass media and inter-personal channels. It will not only promote contraception, but also address the different variables that influence decision making regarding family size. The strategy will also aim at stimulating discussion within the community on how rapidly increasing population is eroding the quality of life for each individual family as also that of the community through the degradation of the physical and ecological environment.

5.5 The preparation of software and messages will be professionalised by involving the private advertising agencies. The medical and para-medical workers will also be given proper education particularly about the safety and efficacy of spacing methods so that they could communicate convincingly with the people. In order to ensure that the messages put forth continue to be effective and meaningful, regular system of evaluation will be set up. Eminent communication experts from official and non-official

areas will be associated to assess the reach and effectiveness of the communication programme periodically in different areas. Campaign strategies will be revised in the light of this feedback.

5.6 Preparation of software based on regional, folk and traditional arts will be encouraged by setting up Regional Communication Resource Centres. These Centres will promote local skills of departmental workers and also take help from non-official bodies for designing, producing and evaluating the software including communication aids. They will also help in designing and implementing the training modules for basic health workers. The communication and extension personnel will be selected with care and on the basis of their professional capabilities for communication work. Wherever the reach of mass media like radio and television is insufficient, the interpersonal communication will be specially strengthened and made more efficient. Besides improving the knowledge and communication skills of the basic health workers, attention will be given to improving their image and credibility in the community.

#### POPULATION EDUCATION

5.7 Population Education - Internalised to the whole spectrum of education system can greatly help in influencing the fertility behaviour of the coming generations in the desired direction. In 1981, out of 685 million population, there were 181 million children in the school age group of 6-17. Out of these, there were 106 millions in the schools. There are about 3.14 million students going to colleges and universities. The potential of population education in the formal and non-formal system will be fully harnessed. Training of resource/key persons, instructional material for different target groups and preparation of population education lessons will be the crucial activities for the success of population education programme. A high level committee will be set up to oversee and co-ordinate the programme.

5.8 Assistance from the United Nations Fund for Population Activities (UNFPA) was made available to enable the Ministry of Education to initiate projects for imparting population education during

the Seventh Plan with specific quantitative targets :

	<u>Target Group</u>	<u>No. to be covered</u>
(i)	Students in the age group 6 to 16 or classes I - X	56.44 million
(ii)	Students in the age group 16-18 or classes XI - XII	2.75 million
(iii)	Out of school children in the age group of 9-14	45.06 million
(iv)	Teachers in Primary, Middle and Secondary Schools	2.49 million
(v)	Teachers in Higher Secondary Schools	0.26 million
(vi)	Instructions in Non-formal Education Centres	0.15 million
(vii)	University/College students	3.14 million
(viii)	University/College Teachers	0.21 million

It is recommended that for the students at 10 + 2 stage and college-going students, Population Education should include compulsory lessons on family life cycle to make them fully aware of the essentials of reproductive physiology and contraception. Population education through the non-formal school education system will be strengthened to cover the 45 million children out of schools. A population project has been developed for adults in the age-group of 15-35 under the Adult Education Programme. This project will greatly help in motivating this highly fertile age-group to limit their family size.

5.9 In the organised sector, there are 24 million workers who are involved in group activities. Trade union leadership and employers associations will be motivated to arrange population education amongst the members/employees. Population education will also be included in all the curriculum of vocational schools. This scheme will also be extended to unorganised sector on the pattern of pilot project

for Bidi Workers by identifying suitable groups like handloom weavers and plantation workers. Nehru Yuvak Kendras, Mahila Mandals and Co-operatives will also be encouraged for imparting population education. Messages and materials will be developed by expert groups.

5.10 An integrated approach by the functionaries of various developmental departments at grass-root levels in promoting family planning will greatly enhance programme acceptance. A mechanism will be established whereby all these functionaries will inter-act with community not only in family planning, but in the entire range of programme of social engineering. The sub-centre can act as nucleus where liaison between the primary functionaries of different departments could be operationalised and linkages established with the public representatives. Their inter-action will have to be under the supervision of Panchayat Samities or Village Panchayats. The Block Extension Educators would be assigned the task of bringing into inter-play communication between the functionaries of different departments.

#### INCENTIVES

5.11 Incentives which seek to directly influence fertility behaviour can play a crucial role in population control strategy. At present, some incentives are available to the employees of Central Government, Public Sector Undertakings and State Governments. Central Government does not give any incentives to the members of the general public except a small amount by way of compensation for the loss of wages. Some States have introduced incentives in the form of lottery ticket scheme and a scheme of issuing Green Cards which entitle the acceptors of sterilisation with two or less children, preferential treatment in certain areas. It is necessary to review the entire system of individual and community incentives. It is felt that any scheme of incentives should follow a differential approach encouraging limitation of family size within two children. Following are some of the incentive schemes which could be considered for introduction in the programme:

- An economic incentive to the small family to be built into all the Socio-economic Development programmes of the Central and State Governments which are beneficiary oriented. A preference is to be given for the two or less child family norm in the selection of the beneficiaries and also additional subsidy/grant and an interest rebate is to be granted on loan payment.

- Schemes being considered for these economic linkages are the IRDP, NREP, RLEGP and other rural development programmes of assistance to individuals, loans under agriculture training and employment schemes, loans under small scale and village industries, welfare schemes of all beneficiary-oriented development corporations, insurance schemes, bank and co-operative loans, allotment of land and housing and such other activities as have a strong bearing on the citizens' life.

These benefits will be subject to a small family acceptor being eligible otherwise under a particular scheme. The non-governmental sector including corporate sector and voluntary sector is to be persuaded to implement the same economic linkages under their activities.

Acceptors of sterilisation with two or less children may be given 'Honoured Citizen Cards' which will entitle them to preferential treatment in all possible areas where facilities are available to the public.

- Acceptors of sterilisation after two or less children will be entitled to an Insurance Policy of high value but low premium to serve them in old age.

- A National Lottery Scheme for acceptors of sterilisation with two or less children offering attractive prizes.

- Issuing of bonds of the face value of Rs.25,000 maturing after 15 years to acceptors of sterilisation having two female children. Such a scheme will help in raising the age of marriage of women, their status and neutralise the male offspring preference.

- Community Awards for Pariwar Kalyan Villages which exceed contraceptive prevalence of 70 per cent.

- State and National merit system and awards/recognition to workers, programme managers at various levels, individuals and corporate bodies in the private sector and voluntary organisations.

## CHAPTER VI

### VOLUNTARY ACTION

#### Non-Governmental Structures

6.1 Family Planning has to be made a people's

movement. Non-Governmental structures will be promoted to supplement and strengthen the Family Planning activities. The following major initiatives will be taken in this regard:

- All voluntary organisations, irrespective of their present field of operation will be encouraged to work in the sphere of family welfare and depending upon their capabilities they can take up motivational and educational work as also the task of providing services. A Committee for Supportive Voluntary Action (SCOVA) will be established which will provide consultancy services, identify suitable voluntary organisations, sanction financial assistance to them and monitor their performance. Procedures for giving grants will be simplified. An estimated number of 70,000 voluntary organisations exist in the country with the membership of nearly 1.75 million. The aim will be to involve the maximum number in the programme at all levels.

- The organised sector has a total of over 25 million employees. Organised sector units will be persuaded to provide family welfare services to their employees and make available to them a minimum prescribed package of rewards and incentives. Larger units will also be persuaded to adopt areas and townships for intensive family planning motivation and service delivery. A Tripartite National Committee of Government, Employers Association and Trade Unions is being constituted to exploit the potential of the organised sector.

- There are nearly 35,000 Co-operatives in the country covering 95% of villages and almost 50% of rural population. These are well-knit units with functional linkage systems that join the village to the district and State to the National level agencies. This sector will be used to act as a conduit for education, communication and motivational activities. Specific projects will be designed and entrusted to the Co-operative sector in areas where they have institutional facilities and capabilities.

- The professional and financial capabilities of the Corporate sector will be harnessed by offering suitable tax incentives for setting up corporate structures for providing integrated family welfare services.

## COMMUNITY PARTICIPATION

6.2 Community participation is vital for programme success. Following approaches will be pursued to secure full-scale community participation, particularly at the grass-root levels so that the concept of family planning is internalised in the social polity.

- Popular Committees consisting of Government officials and eminent public leaders will be organised at State, District, Block and Panchayat levels for planning and overseeing the implementation of motivational and service delivery aspects of the programme. At least half of the members of these Committees will be women.

- Special schemes will be developed for involvement of Organisations of Women and Youth such as Mahila Mandals and Youth Clubs in the Family Welfare Programme integrated with socio-cultural activities which such organisations are engaged in.

- Medical students will be given proper orientation in community work through suitable restructuring of their syllabus. General student community will also be involved through a scheme of compulsory rural and urban slums work as part of the educational programme. The involvement of the student community will be for over-all community development within which health and family welfare issues will have a primary focus.

- The Parliamentarians, Members of State Legislatures, Zila Parishad Members, District Committee Members, Block Pramukhs, Gram Panchayat Members, Gram Pradhans, Youth Wings and Mahila Wings of the political parties, irrespective of their party affiliations, can bring about significant change in people's attitudes to family planning. They will be involved in motivational work.

- It can also be considered whether the front organisations of the political parties, especially those of Women, Youth and Students can encourage their members to take a pledge to observe and promote small family norm. This pledge administered in large rallies will have good demonstration effect.

- The large reservoir of practitioners of Indian Systems of Medicine will be harnessed to further the programme. They will be involved not only in

motivational work but also in providing the services according to their capabilities. A scheme will be launched to improve their technical, managerial and motivational skills to get their best support for the programme.

- The Opinion Leaders Training Camps will be more effectively organised in close co-ordination with Primary Health Centres and voluntary organisations in the local area. Apart from providing orientation, these Camps will also serve to extend family planning services.

### Women Volunteer Corps

6.3 A village level Women Volunteer Corps will be organised. The volunteers would interact with the eligible couples in their areas and provide them with knowledge of health, immunisation, family planning, nutrition, etc. They would be given proper orientation training for this purpose. Women volunteers will be chosen at the rate of one for every 60 families both in rural and urban areas. These volunteers will be preferably those who are acceptors of family planning with three or less children and will be selected from amongst the concerned group of eligible couples. The role of women volunteers is not limited to family planning, but would include overall emancipation of women. A cadre of approximately 2 million such workers from within the community will be a major catalyst for social change.

### Social Marketing of Contraceptives

6.4 The programme of social marketing of Nirodh has been in existence for the last 15 years and is being executed through 12 large and well established private and public sector undertakings. The sale of Nirodh through these channels was 16 million pieces in 1968-69 and is expected to cross 300 million next year. Even though there is sufficient awareness on the part of the consumers about Nirodh, adequate infrastructure and delivery system, the main job of creating a large demand leaves much to be desired. This demand creation depends upon aggressive marketing, advertising and product promotion. The present Cell in the Ministry is ill-equipped for mounting a large scale and successful programme. A marketing board

will be set up in the Ministry to review periodically the policy on social marketing, draw up an action programme and oversee its implementation. This Board will have as Members, experts on marketing and communication. The Board will ensure a cohesive and integrated approach to marketing, provide policy guidance and Central Management Coordination, sales forecasting, review and related management support services.

6.5 Greater involvement of Marketing Companies will be enlisted and their responsibilities and areas of operation broadened. Better quality condoms will be introduced in the Social Marketing System. Apart from popular retail outlets, non-conventional outlets will also sell contraceptives. The main thrust will be that people should be able to purchase condoms in an impersonal atmosphere from easily accessible places.

6.6 The social marketing programme will also be extended to include oral pills and other spacing contraceptives. While extending the social marketing programme, free distribution of contraceptive will be scaled down. Community based distribution system worked by voluntary organisations will also be considered for participation wherever necessary. All these steps will lead to much higher level of knowledge and achievement than what has been targeted in the 7th Plan.

## CHAPTER VII

### IMPROVING PROGRAMME MANAGEMENT

7.1 Experience has shown that in States where programme has been handled more efficiently, performance has improved significantly. An analysis of the existing situation based on the research findings reveals that inadequate administrative structure, lack of management system at P.H.C. level, insufficient mobility, deficient supply systems, shortage and poor maintenance of equipments are some of the basic weaknesses in the programme. All these areas will be given priority and focussed attention.

7.2 At the National level, the administrative structure in the Department of Family Welfare will be reorganised and reoriented towards modern programme management. A number of initiatives will be taken to build professionally competent structures and sub-structures manned by most suitable resource persons so that policy, planning, implementation, review

and evaluation aspects of the programme are handled with maximum efficiency. There will be apex level bodies to review the policies, programme and their implementation. Separate satellite structures will be established within the Ministry for giving advice and direction on specific aspects of the programme. Full use will be made of the specialised autonomous organisations such as National Institute of Health & Family Welfare, Indian Council of Medical Research, International Institute for Population Sciences for the overall planning, decision making and implementation of the programme.

7.3 At the State level, there will be a high powered Committee for overall review and monitoring. Posts of Additional Chief Secretaries would be created in certain States for more effective coordination of family welfare with other social sector programmes. State Family Welfare Bureau would be strengthened and State level institutions like Population Research Centres will inter-act more effectively with the State machinery.

7.4 At the District level, the Collector will be invested with the overall supervisory responsibility of the programme to forge effective coordination. A Popular Committee will be set up under his leadership to serve as an instrument of bringing together various resources in the district for a common Action Plan. The Chief Medical Officer will serve as the principal resource to the Collector and his position will be strengthened. District Family Welfare Bureau will also be adequately strengthened in line with the district-wise thrust in the programme.

7.5 At the Block level, the Block Development Officer will be fully involved in the programme. A mechanism will be established by which he will get support and advice from various Government departments and popular institutions. He will coordinate and mobilise the functionaries of different development departments and work in close collaboration with the Medical Officers in charge of Primary Health Centres.

#### Improving Primary Health Centre Management

7.6 The Primary Health Centre at the Block level is a critical unit in the service delivery system. Planning and management of the programme in the Primary Health Centre requires talents of a Manager apart from the skills of an Epidemiologist. The Medical Officer in charge of the Primary Health Centre will have to be trained in the skills of programme planning

and management so that he can organise both official and non-official agencies for proper delivery of Family Planning and MCH services. A detailed exercise would be undertaken to assess management needs of the Medical Officer in charge of Primary Health Centre and of the functionaries working below him and modules developed for on-the-job and off-the-job training of these functionaries and a structure of incentives will be built up, allowing for upward mobility in their professional careers based on commitment and objective performance.

### Improving Mobility, Streamlining Supplies and Equipments

7.7 Mobility is of prime importance for service delivery, supervision and emergency assistance. Regular availability of supplies and equipments is vital to the success of the programme. Following steps will be taken to improve the existing situation in these areas:

- Vehicles under the programme will be maintained at optimal efficiency. Old vehicles will be replaced and additional vehicles provided for districts of large size and difficult terrain.

- Para-medical workers will be given interest free loans to purchase Mopeds/Motor Cycles for their official use to increase their mobility and efficiency. Adequate allowance will be given to enable them to maintain the two wheelers and to meet the POL costs.

The necessary supplies and equipments like surgical instruments, refrigerators, vaccines, contraceptives, audio-visual equipment, will be regularly made. Their proper upkeep and maintenance will be ensured. Appropriate training will be given for scientific management of inventories.

### Eligible Couple Registration System

7.8 Eligible Couple Register is the basic document for organising the work programme of Family Planning field workers. There are about 126 million eligible couples and this number is likely to increase to around 170 million before 2000 A.D. The system of preparing Eligible Couple Registers will be streamlined to make it an effective instrument of monitoring and management. Each functionary will have registers of couples falling within his jurisdiction. These will be regularly updated and definite responsibilities fixed for their preparation and authenticity of

information. The Eligible Couple Roll will be printed and displayed at accessible points in each village for public scrutiny. These registers are vital in proper enforcement of a system of structured incentives apart from improving information on the vital statistics.

### DIFFERENTIAL AREA, REGION AND GROUP SPECIFIC APPROACHES

7.9 The socio-economic conditions and demographic situation in the country vary considerably from State to State and within a State, from region to region. This diversity dictates the need for differential approaches and region specific strategies. These are:

#### State Level

- Each State will devise its strategy to achieve the goal of unity NRR by the year assigned to it, besides preparing medium term Action Plans for the remaining period of the Seventh Plan. Each State will carry out a situational analysis to identify thrust areas and devise differential approaches for different districts, areas, communities and groups. To enable the State to efficiently implement their strategies, greater decentralisation and flexibility in implementing the programme will be provided.

#### District Level

- Based on the State level strategy, each District will prepare an Action Plan for the next four years, which will include all aspects of planning, implementation, monitoring and evaluation. Specific targets to be achieved will be decided by the State Family Welfare Bureau in consultation with the District Family Welfare Bureau.

#### Block/PHC Level Action

- The Medical Officers in charge of the PHC will prepare Action Plan for the Block for extensive coverage of all eligible couples. This will include updating of Eligible Couple Registers, identification of low acceptance villages, schedules of holding family planning and immunisation camps and well planned supportive supervision.

#### Municipal/Urban Areas Special Strategy

- Population in poor pockets of urban areas is growing very fast. Most urban areas have Health & Family Welfare infrastructure, but that is 'clinic'

oriented. The approach will have to be changed to a community-based motivation and extension services. Adequate coordination, lacking at present, will be provided among various health institutions and voluntary organisations will be mobilised in providing comprehensive and coordinated services.

### Lagging Groups and Communities

- Owing to various socio-economic reasons, acceptance of family planning amongst certain communities and identifiable groups is relatively much lower than the national level of acceptance. Each State and District will identify such groups and regions, assess their attitudes and perceptions and devise group specific programme of packages. A special feature will be to involve members of the lagging community groups, both for motivational work and for providing services. A package of group specific communication messages, special focus on education, provision of better facilities and involvement of members of specific groups will help in reducing the variations which now exist.

## PROGRAMME COORDINATION

### Intra-sectoral Coordination

7.10 A large number of agencies in Government, voluntary and corporate sectors are engaged in promoting family planning in one way or the other. There is no system of effectively coordinating their efforts in a purposive manner on regular basis. It is essential to harmonise the work of the various institutions and ensure that experience gained is commonly shared. For this purpose, specific tasks will be assigned to various agencies to avoid unnecessary duplication and a standing mechanism will be established for sharing of experiences and concerted joint action.

### Inter-Sectoral Coordination

7.11 Socio-economic development which is a major correlate of fertility is a process of overall national development effort. While it is the responsibility of the Ministry of Health and Family Welfare to promote contraception and provide necessary services, the responsibility to gear up efforts for economic and other developments which will help in fertility reduction falls within the purview of other Ministries. Apart from this, other Ministries will also have to inbuild some component of Family Planning in their

programmes. All socio-economic development schemes should have family welfare as an integral component. While dispensing benefits of various development schemes, other things being equal, preference should be given to those who observe two-child family norm. A standing mechanism will be set up at the Centre and in the States for securing effective intersectoral coordination from the National to the grassroot level of all the relevant Ministries, Departments and agencies.

### MANPOWER DEVELOPMENT, TRAINING

#### AND PERSONNEL POLICIES

7.12 Manpower Development is an essential element of programme improvement efforts. Doctors and para-medicals need to be trained for being developed into health administrators, programme managers and for rendering specialised family planning services. Para-medical personnel constitute the peripheral point of the delivery of family welfare services. Adequate facilities for training these categories exist except for male MPWs, which would have to be created. However, a general strengthening of these institutions in terms of faculty and equipment would also be necessary.

7.13 Awareness of family planning programme is nearly universal but acceptance rate is estimated to be only 35%. The role of extension personnel at village level becomes crucial for converting awareness into acceptance. This needs inter-personal communication skills. To impart necessary skills, communication training needs will be identified and training programmes introduced/reoriented.

7.14 There are nearly 6 lakh traditional birth attendants who conduct majority of the deliveries. Dai enjoys the position of an influential opinion leader in matters of maternal and child health. They, thus, constitute an excellent potential of developing into an effective agent for providing pre-natal care, aseptic delivery and post-natal care. To draft dai as an effective sales person for Family Planning/MCH services, her opposing interests to family planning would have to be neutralised through an incentive scheme. As the number of dais is declining, new entrants would be encouraged through suitable schemes.

7.15 The Village Health Guide Scheme aims at involving community in health and family welfare programmes. Improper selection, inadequate training and incorrect implementation has resulted in

unsatisfactory performance of the scheme. Male Health Guides are sub-salient in family welfare services which mainly relate to women. It has been decided to replace all the male Health Guides by female Health Guides.

7.16 The reluctance of doctors to move into rural and remote areas makes it imperative to think in terms of introducing a new category of health personnel with skills intermediate to those of doctors and para-medical workers. These Community Health Supervisors would be imparted training for a period of three years and equipped to deal with majority of the common ailments of the rural people nearest to their doorsteps. They would also become an effective link between the peripheral worker and the medical officer and thus be able to contribute substantially in the area of supplies and services of family planning programmes.

7.17 Under-utilisation and low quality of services highlight the need for an intensive training of the family planning workers. Areas critical for programme performance will be identified. An exercise of assessing training needs will be carried out for each PHC. Regional training institutions will be strengthened to provide a continuing education programme to cover each health worker for a period of training upto three weeks once in five years. We have at present 7 Central Training Institutes and 47 Regional Health and Family Welfare Training Centres. About 8 lakhs para-medical and extension workers of different categories would need to be covered. To cover these workers, in addition to the existing infrastructure, PHCs and sub-centres are also to be developed as training resources.

### Personnel Policies

7.18 A scheme of career development would be implemented to provide for adequate opportunities for upward mobility to various health functionaries combining merits and experience.

## CHAPTER VIII

### RESEARCH, MONITORING AND EVALUATION

#### Family Planning Research

8.1 Family planning research is a very critical element for improving the quality and effective outreach of the programme. The main thrust would be to make research directly relevant to the programme needs.

Following are the major areas which will receive priority.

- The Research Study 1986 as well as other Studies done in the past have provided better understanding of people's response to family planning in terms of their socio-economic conditions, values and perceptions, availability and accessibility of services and suitability of the existing contraceptive methods, etc. This has helped in devising appropriate programme policies and strategies. Since human society is dynamic, similar psycho-social research will be taken up in future as a regular feature.
- It is commonly believed by the Demographers that the couple protection rate of 60% will reduce the birth rate to 21. The validity of this hypothesis needs to be investigated empirically through field studies. Towards this end, a rigorous and properly designed research project will be commissioned.
- High priority will be given to operational research aimed at bringing about more effective utilisation of the current delivery system and in identifying alternative and cost-effective strategies.
- Research focus will be given on improving the acceptability of the existing methods by minimising the complications/inconveniences associated/perceived to be associated with them.
- New technologies like injectables, sub-dermal implants are currently undergoing trials prior to their introduction in the programme. The procedures and protocols of induction of new technologies will be reviewed to enable faster introduction of such technologies in the programme.
- Development of simple, reversible, safe and long-acting contraceptive such as AntiFertility Vaccine would seem to offer greater potential. Research efforts in developing such a vaccine will receive high priority. At the same time, contraceptive research by the Research Councils in the Indian Systems of Medicine will also be expedited.

### Management Information System

8.2 A Management Information System will be developed from the sub-centre level upwards to the national level. This system will have two functions. The first is to generate necessary information at the ground level and beam it upwards through PHCs

to the district level and above. This will facilitate monitoring and evaluation of the performance. Secondly, the system will really information, guidance and feedback from higher levels to lower formations. Information collected at each level will be critically analysed in order to identify gaps and enable corrective responses.

### Monitoring and Evaluation

8.3 A proper Monitoring and Evaluation system must provide for bench-mark data, periodic review, and evaluation of performance with a view to ensuring that the programme is moving on the lines laid down, in the time-frame prescribed and most importantly, produces the results which are sought to be achieved. States have the bench-mark data in terms of birth rates, deaths rates and infant mortality rates. Such data are not available at the district levels. For a proper monitoring and evaluation of the programme, a system will have to be devised to collect such baseline data for the districts. Thereafter, what has to be achieved during the next 4-5 years will have to be targeted.

8.4 Various targets for Family Planning and their method-mix will be decided to reach the target<sup>d</sup> levels of birth rate, death rate, etc. The specific activities which need to be organised will be spelt out for each district yearwise. When this is done, it would be possible for the programme managers at higher levels to monitor the programme performance to see whether the activities are being performed on time and in the manner desired. This will facilitate mid-term corrections wherever necessary.

8.5 A system of concurrent evaluation will be introduced so that the quality of services being provided and the programme impact can be assessed from time to time in a more effective manner. The impact measurement in terms of reduction of fertility and mortality rates will be the most important index of the evaluation system and a semi-independent mechanism will be set up to continuously monitor the impact of the programme on birth rates and age specific fertility rates. The system should enable computation of the birth rate at any point of time obviating the time lag of waiting for the SRS estimates.

### Computerisation

8.6 Monitoring and evaluation of the programme will be computerised firstly at the national level and subsequently at district levels. The programme

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of computerisation will be synchronised with the growth of the computer network NICNET of the National Informatics Centre. Currently, the facilities of the National Informatics Centre are being used to monitor and evaluate the achievements of the States in various programme components, setting of targets, etc. It is proposed to utilise the nation-wide network for linking the National Headquarters with the Regional, State and District Headquarters. Computer will be utilised to monitor the performance of each Block; vacancy positions; establishment of PHCs and Sub-Centres; evaluation of the impact on birth rates and age specific fertility rates. Appropriate software will be developed to measure cost-effectiveness of various schemes under the programme.

### CONCLUSION

9.1 Containing rapid population growth calls for long-term and a short-term strategy. This document outlines the strategy which may be followed during the current Plan period. Operationalisation of these strategies and the success of the small family movement depends upon sustained political will and commitment on the one hand and improved programme management with innovative strategies on the other. The latter, inter alia, includes energising infrastructure, improving status of women, revamping communication and population education activities, inter-sectoral coordination, manpower development, training and improved monitoring, evaluation and research, and differential area/group approaches and incentives.

9.2 Efforts will be made by the Department to make the Family Planning Programme maximally cost effective so that the new approaches and schemes are accommodated to the extent possible within the present VII Plan outlay of Rs.3250 crores. Most important component of the Strategy is to secure increased people's participation in this vital programme thereby making it a massive 'people's movement'.

9.3 The strategy as enunciated in this document has to be discussed and approved expeditiously so that it can be speedily translated into action and the country steered to the target path of population stabilisation.

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